AXA EQUITABLE

AXA Equitable Life Insurance Company

AXA Life and Annuity Company

DATE OF ISSUE: AUG 31, 2006

DELIVERY RECEIPT

By signing below, I(we) certify and acknowledge that:

(1) I(we) have received Policy Number: 156 220 265

on the life (lives) of ZHOU FANG

and _____

The contract state is NEW JERSEY

(2) Unless I(we) meet the terms of coverage under the Temporary Insurance Agreement, coverage under this Policy will begin on the date this receipt is signed and given to an AXA Equitable representative along with the first modal premium payment. In that event, AXA Equitable will move the Register Date of my Policy showing in the Policy Pages to the date of delivery to insure that the charges and premiums for the Policy commence on the same date as coverage under the Policy, unless I(we) request a different Register Date in writing or moving the Register Date will cause an increase in Issue Age(s).

(3) All persons proposed for insurance under this Policy are living and insurable as described in each part of the application for this Policy.

(4) For those Policies delivered on the 29, 30, or 31st of any month, AXA Equitable will move the Register Date to the 1st of the following month, which will change the Investment Start Date, if applicable, and the Interest Crediting Date, if applicable. Further, the current Interest rate for the Guaranteed Interest Account, if applicable, or the current interest rate for UL policies, if applicable, may also change.

Signed At PRINCETON, NJ
City, State

Date 9-17-06 Signed (X) ZHOU FANG

Date _____ Signed X _____

Agent: TANG HARRIS C ASU MLO

Servicing Office:

Claims Office: 800-777-6510

AXA EQUITABLE NATIONAL OPERATIONS CENTER
POST OFFICE BOX 1047
CHARLOTTE, NORTH CAROLINA 28201
(800) 777-6510

POLICYOWNER'S COPY

DR(2)

AMENDMENT TO APPLICATION

Name of Proposed Insured ZHOU FANG (First / Middle Initial / Last) Application Dated JUL 29, 2006

Policy No 156 220 265

TO AXA EQUITABLE LIFE INSURANCE COMPANY

The application is hereby amended by the undersigned in the following particulars:

MY ASSOCIATE HAS PROVIDED A PROPOSAL ILLUSTRATING THE VALUES OF THE CONTRACT AS ISSUED.

ISSUE WITH GUIDELINE PREMIUM TEST.

This amendment is to be taken as a part of said application, subject to the agreement therein contained; said application and this amendment thus taken as a whole are to be considered as the basis for and as a part of the policy. To the best of my knowledge and belief, in all other respects the statements and answers in the application continue to be, without material change, true and complete as of the date of this amendment.

Dated at _____ (City) _____ (State) on _____ ____

_____ Signature of Purchaser if other than Applicant

_____ Signature of Applicant

Agent; _____

Agency:

☐ AXA Equitable Life Insurance Company
1290 Avenue of the Americas
New York, NY 10104

☐ MONY Life Insurance Company of America
1290 Avenue of the Americas
New York, NY 10104

Application For Life Insurance
Part I
Form No. LIFEAPP-GV
(2005)

1 PROPOSED INSURED (Print Name as it is to appear on the policy.) Please print in ink.

Proposed Insured

A. Full Name: First ZHOU M.I. _____ Last FANG B. Gender: ☒ Male ☐ Female

C. Home Address: 351 state Road _____
(No. and Street) (Bldg/Apt/Suite)

City/Municipality PRINCETON County/Parish _____ State NJ Zip + 4 Code 08540
(If address is a P.O. Box or not actual residence, proof of residence required.)

D. Home Phone No. 609 688 0409 Best time to Call: _____ Best phone no. to be contacted: _____

E. Date of Birth: 01-11-1966 (Month/Day/Year) F. Place of Birth: China (State/County)

G. Marital Status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced ☐ Separated H. Soc. Sec. No. 151041891

I. Driver's Lic. No.: F0418 79600 0166Z State: NJ

J. U. S. Citizen? ☐ Yes ☒ No* If No, Country China U.S. Visa type Green Card Passport # or U.S. Visa # _____ # of years in U.S. ____

K. Currently employed? ☒ Yes ☐ No ☐ Retired

L. Current Occupation(s): (1) Title: Small Business Owner (2) Duties Remodeling (3) How Long? 6 yrs
(If less than 1 year at current occupation, give previous in Remarks.)

M. Employer Name: _____

N. Employer Address: 351 state Road princeton NJ 08540
(No.& Street) (City) (State) (Zip + 4 Code)

O. Annual Earned Income (Income from occupation) $ 46,000 — P. Net Worth $ 225,000 —

* If the Proposed Insured and/or policy owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership, or Trust established or organized under the laws of a state of the United States) then he, she or it may have to provide additional documentation, including IRS form W-8 BEN.

2 COVERAGE INFORMATION

A. Plan of Insurance Athena Universal Life II Amount of Insurance $ 180,000 —
(If survivorship policy, complete an application for each Proposed Insured. If VUL, must also complete VUL Supplement. To select dividend options on EWL or Riders on all Non-VUL Plans complete Optional Benefits Supplement.)
(If face amount is $2 million or larger complete Financial Supplement.)

B. Complete for UL or VUL only (1) Death Benefit Option ☒ Option A ☐ Option B
(2) Planned Periodic Premium $ 360/Q

C. Definition of Life Insurance Test: Complete for AUL II, IL, IL COLI '04 ☐ Guideline Premium Test ☐ Cash Value Accumulation Test

D. Premium Mode: ☐ Annual ☐ Semi-Annual ☒ Quarterly ☐ Monthly
Or
System-Matic (Complete S-M form and check applicable box) ☐ Quarterly (only available for UL and VUL) ☐ Monthly

E. Salary Allotment (1) Unit Name _____ (2) Unit/Sub Unit. No. _____ (3) Unit Register Date _____
(Specify Allotter name, if other than insured, in Remarks.)

F. Date Policy to save Insured Age? ☒ Yes ☐ No

G. 1. Do you, the owner, intend to use or transfer the policy for any type of pre-death financial settlement, such as viatical settlement, senior settlement, life settlement, or for any other secondary market? ☐ Yes ☒ No
2. Have you, the owner, or any Proposed Insured if other than the owner, in the past 5 years sold a policy to a life settlement, viatical, or other secondary market provider? ☐ Yes ☒ No

H. Any other life insurance now in effect or application now pending? ☐ Yes ☒ No
(Give companies, amounts and policy numbers in Remarks.)

I. Will the coverage applied for replace or change any life insurance or annuities? ☐ Yes ☒ No Is this a 1035 Exchange? ☐ Yes ☒ No
If "Yes", complete: (If additional room is needed, please use Remarks Section.).
Amount $_____ Company _____ Issue Year_____ Policy Number _____ ☐ Life ☐ Group ☐ Annuity
Amount $_____ Company_____ Issue Year_____ Policy Number_____ ☐ Life ☐ Group ☐ Annuity

J. Is this a Term Policy/Rider Conversion or Purchase Option? ☐ Yes ☒ No If **"Yes"**, complete Term Policy/Rider or Purchase Option Supplement.

K. Complete if Proposed Insured is under age 15:
a) State total amount of insurance in force on the life of applicant or child's parent, if greater $_____
b) Are any other children in the family insured for a lesser amount? ☐ Yes ☐ No

If "Yes" give details _____

❸ BENEFICIARY/OWNER

A. Beneficiary (Total designation must be 100%. Use Remarks section for additional Beneficiary information.)

Beneficiary Full Name	Relationship to Insured	Percentage
Primary: JIAN HUA LIANG	wife	100 %
Contingent: EN GUANG FANG	SON	50%
PHOEBE FANG	Daughter	40%

B. Owner (The Owner of this policy is the Insured unless otherwise specified below. Enter name of successor owner in Remarks.)

Provide the Applicant's name, address and Taxpayer ID, if different from the Insured and Owner, in Remarks Section.

If the Owner is the Trust provide the name of the Trust. _____ Social Security # or TIN _____

Owner's Name: _____ City _____ State _____ Zip Code _____

Address: Street _____
(Billing notices will be sent to the Owner at this address unless otherwise directed in Remarks Section.)

U. S. Citizen? ☐ Yes ☐ No* If No, Country _____ U.S. Visa type _____ Passport # or U.S. Visa # _____ # of years in U.S. _____

Relationship to Insured _____ Date of Birth _____

Name of Trustee _____ Date of Trust Agreement _____

* If the policy owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership, or Trust established or organized under the laws of a state of the United States) then he, she or it may have to provide additional documentation, including IRS form W-8 BEN.

❹ GENERAL INFORMATION (Proposed Insured)

List details of all answers in the Remarks section.

A. Ever had a driver's license suspended or revoked, or within the last 5 years, been convicted of reckless or negligent driving or driving under the influence of alcohol or drugs? ☐ Yes ☒ No
(If "Yes", include dates, types of violations, and reason for suspension or revocation in Remarks.)

B. Any plans to travel or reside outside the United States? ☐ Yes ☒ No
(If "Yes", complete Foreign Residence and Travel Supplement.)

C. Have you been disabled for 2 or more weeks within the last 2 years? ☐ Yes ☒ No

D. In the last year flown other than as a passenger or plan to do so? ☐ Yes ☒ No
(If "Yes", complete Aviation Supplement.)

E. Engaged within the last year or any plan to engage in motor racing on land or water, underwater diving, skydiving, ballooning, hang gliding, parachuting or flying ultra-light aircraft or other hazardous sports or hobbies? ☐ Yes ☒ No
(If "Yes", complete Avocation Supplement.)

F. Ever had an application for life or health insurance that was declined, required an extra premium or other modification? ☐ Yes ☒ No
(If "Yes", state companies and provide full details in Remarks.)

G. In the last 10 years, have you been convicted of, or pled "no contest" to a felony? ☐ Yes ☒ No
(If "Yes" in "Remarks", state full details of offense and penalty, with dates.)

H. Do you currently use any form of tobacco or nicotine product? ☐ Yes ☒ No Type _____ Avg. Quantity # packs _____ Frequency _____

I. Have you ever used any form of tobacco or nicotine product? ☐ Yes ☒ No Type _____ Date Ceased _____

❺ MEDICAL INFORMATION (Proposed Insured) Please Note: Complete this section even if a paramedical or medical exam is being ordered.

A. Height 5 Ft. 8 in.; Weight 180 lbs.

B. Personal Physician Name XIAO MEI Chen M.D. 609-918-9100

C. Address 379 PRINCeton Hightstown Rd. cranbury, NJ 08512

D. Date and Reason for Last Visit in the Last 5 Years 2005 for routine checkup

E. What treatment was given or recommended? (If none, so state) none

Has Proposed Insured:

F. Ever had or been treated for heart trouble, stroke, high blood pressure, chest pain, diabetes, tumor, cancer, respiratory or neurological disorder? ☐ Yes ☒ No

G. In the last 5 years, consulted a physician, or been examined or treated at a hospital or other medical facility? (Also include medical checkups in the last 2 years. Do not include colds, minor injuries or normal pregnancy.) ☐ Yes ☒ No

H. In the last 10 years:

1. Used, except as legally prescribed by a physician, tranquilizers, barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances? (If "Yes", complete Substance Usage Supplement.) ☐ Yes ☒ No

2. Received counseling or treatment regarding the use of alcohol or drugs including attendance at meetings or membership in any self-help group or program such as Alcoholics Anonymous or Narcotics Anonymous? (If "Yes", complete Substance Usage Supplement.) ☐ Yes ☒ No

I. In the last 10 years, been:
Diagnosed with, or treated for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? ☐ Yes ☒ No

J.

Family History	Age if Living	Cause of Death	Age at Death
Father	78		
Mother	71		
Sibling	45, 36		

6 **DETAILS OF ALL "YES" ANSWERS FOR MEDICAL INFORMATION** (Attach additional sheet of paper if necessary; and it must be signed and dated by the Proposed Insured, Owner, and financial professional.)

Question No.	Illness, Treatment, and Number of Attacks (include specific diagnosis and medication)	Onset Date	Recovery Date	If disabled, How long?	Doctor, Clinic, or Hospital Complete Address, and Phone Number

REMARKS
Provide details for any of the questions, and any other additional remarks. If the owner is a Qualified Plan, please indicate the qualified plan and type here. (Attach additional sheet of paper if necessary; and it must be signed and dated by the Proposed Insured, Owner, and financial professional.)

This is a preferred client program.

7 **COMPLETE IF MONEY IS PAID WITH THE POLICY:**

Amount paid with this Application: $ _____

Has the undersigned read, signed and received a copy of the Temporary Insurance Agreement, and do they agree to the conditions of the Temporary Insurance Agreement, including:

(i) the requirement that all of the conditions in that Agreement must be met before any temporary insurance takes effect, and

(ii) the $1,000,000 insurance amount limitations, and

(iii) that the Person Proposed for Insurance is at least 15 days of age and not older than 75 years of age? ☐ Yes ☐ No

If "No," or if any Person Proposed for Insurance has been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession within the last 10 years or had cancer, a stroke, or a heart attack within the last year, a premium may not be paid before the policy is delivered.

AGREEMENT. Each signer of this application agrees that:

(1) The statements and answers in all parts of this application are true and complete. We (the Company checked on page 1 of this application) may rely on them in acting on this application.

(2) The Temporary Insurance Agreement states the conditions that must be met before any insurance takes effect if money is paid before the policy is delivered. Temporary Insurance is not provided for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.

(3) Except as stated in the Temporary Insurance Agreement, no insurance shall take effect on this application: (a) until a policy is delivered and the full initial premium for it is paid while the person(s) proposed for insurance is (are) living; (b) before any Registered Date specified in this application; and (c) unless to the best of my (our) knowledge and belief the statements and answers in all parts of this application continue to be true and complete, without material change, as of the time the full initial premium is paid.

(4) No financial professional or medical examiner has authority to modify this Agreement or the Temporary Insurance Agreement. Or to waive any of our rights or requirements. We shall not be bound by any information unless it is stated in Application Part 1 or Part 2 (Paramedical or Medical exam).

(5) I acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable.

☐ AXA Equitable Life Insurance Company ☐ MONY Life Insurance Company of America

ACKNOWLEDGEMENT OF UNDERWRITING PRACTICES

I (we) acknowledge that I (we) have received a statement of the Underwriting Practices of the Company (ies) which describes from whom and why the Company (ies) obtains information on my (our) insurability, to whom such information may be reported and how I (we) may obtain it. The statement contains the notice required by the Fair Credit Reporting Act.

AUTHORIZATIONS

TO OBTAIN HEALTH INFORMATION

I (we) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy or other health care provider, health plan or insurance company (including our Company, with respect to other coverages), or any prescription drug or pharmacy benefit manager or administrator, and the Medical Information Bureau to disclose to the Company (ies) and its authorized representatives any and all information, whether fact or opinion, they may have about any diagnosis, treatment, prognosis, genetic test records, findings and/or results regarding my (our) past, present or future physical or mental condition.

TO OBTAIN NON-HEALTH INFORMATION

I (we) authorize any employer, business associate, government unit, financial institution, consumer reporting agency, the Medical Information Bureau, my (our) insurance agency and my (our) financial professional to disclose to the Company (ies) and its authorized representatives any information they may have about my (our) occupation, avocations, finances, driving record, character and general reputation. I (we) authorize the Company (ies) to obtain investigative consumer reports, as appropriate.

PURPOSE OF AUTHORIZATIONS

I (we) understand that the information obtained will be used by the Company (ies) to determine my (our) eligibility for life insurance coverage and such other uses specified in accordance with the Underwriting Practices attached to this application. In addition, information may be disclosed to the Medical Information Bureau (MIB) who, upon request, may disclose such information about you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable law. If a policy is issued to me (us), this information may also be used in the future to administer my (our) policy and process claims made under the policy.

COVERAGE CONDITIONS

I (we) understand that the Company (ies) is conditioning the issuance of coverage on the provision of this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

ADDITIONAL AUTHORIZATIONS

You have advised me (us) that the Company (ies) may request additional authorizations in order to obtain the information the Company (ies) needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy, I (we) understand that I (we) am (are) not obligated to provide these additional authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION

Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company (ies) declines my application for coverage or, if a policy is issued, 24 months from the date of my (our) application. I (we) understand that I (we) may revoke my (our) authorizations at any time, except to the extent that the Company (ies) has taken action in reliance on this authorization, this application and any claim made under the policy, if issued, may be rejected. My (our) revocation must be submitted in writing to: Chief Underwriter of the Company checked above and on the front page of this application, 1290 Avenue of the Americas, New York, New York 10104.

COPY OF AUTHORIZATIONS

I (we) have a right to ask for and receive true copies of this Acknowledgement and Authorization Form and all other authorizations signed by me (us). I (we) agree that reproduced copies will be as valid as the original.

FOR THE APPLICANT'S PROTECTION, THE LAWS OF CERTAIN STATES REQUIRE THIS NOTICE: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, FILES AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT AS TO ANY MATERIAL FACT MAY BE GUILTY OF INSURANCE FRAUD, WHICH MAY RESULT IN LOSS OF COVERAGE UNDER THIS POLICY AND MAY SUBJECT THE APPLICANT/CLAIMANT TO CRIMINAL PROSECUTION.

SOCIAL SECURITY OR TAX I.D. NUMBER CERTIFICATION---UNDER THE PENALTIES OF PERJURY, I CERTIFY THAT (I) THE NUMBER SHOWING ON THIS FORM IS MY CORRECT TAXPAYER IDENTIFICATION NUMBER, AND (II) I AM NOT SUBJECT TO BACKUP WITHHOLDING BECAUSE (A) I AM EXEMPT FROM BACKUP WITHHOLDING OR (B) I HAVE NOT BEEN NOTIFIED BY THE INTERNAL REVENUE SERVICE (IRS) THAT I AM SUBJECT TO BACKUP WITHHOLDING AS A RESULT OF A FAILURE TO REPORT ALL INTEREST OR DIVIDENDS OR (C) THE IRS HAS NOTIFIED ME THAT I AM NO LONGER SUBJECT TO BACKUP WITHHOLDING, AND (III) I AM A U.S. PERSON (INCLUDING A U.S. RESIDENT ALIEN).
CERTIFICATION INSTRUCTIONS: You must cross out item (ii) above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return.
THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISIONS OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHHOLDING.

I (we), the undersigned, by my (our) signature(s) below understand that I (we) am (are) agreeing to all the terms and conditions of this application, including, but not limited to, the Acknowledgement and Authorization.

Dated at City PRINCETON

State NJ

on 7 29 2006

(X) _____
Signature of Proposed Insured, Applicant, or parent or guardian, if Proposed Insured is a Child, Issue Ages 0-14

_____
Signature of Owner or Applicant if not Proposed Insured
(If corporation, print firm's name and signature of authorized officer.)
(If trust, signature of trustee.)

Financial Professional to complete this section:

Will any existing insurance be replaced or changed (or has it been) assuming the insurance applied for will be issued? ☐ Yes ☒ No

(If "yes" give details _____)

I certify that I have asked and recorded completely and accurately the answers to all questions on the fully completed application Part 1, and know of nothing affecting the risk that has not been recorded herein.

☒ **I have** witnessed the signature required on fully completed Part 1 ☐ **I have not** witnessed the signature required on fully completed Part 1, (Explain below)

_____
Signature of Licensed Financial Professional/Insurance Broker

Print Licensed Financial Professional's Name HARRIS TANG

Application Part 2 To: ☒ **The Equitable Life Assurance Society of the United States**

☐ **The Equitable of Colorado, Inc.**

Reason for submission of this form: ☐ New Policy ☒ Policy Change ☐ Reinstatement

PARAMEDICAL

1. a. Proposed Insured (Please Print) — First Name: ZHOU — Middle Initial: — Last Name: FANG
   b. Height: 5 ft. 6 in. c. Weight: 170 lbs.
   d. Birth Date: 01-11-66
   e. ☒ Male ☐ Female

2. a. Name and address of personal physician (or medical facility used instead): (If none, so state) DR. XIANG 41-98 JAMES ST. SUITE 201, EDISON, NJ 08820
   b. Date and reason last consulted if within the last 5 years: 2005 - PHYSICAL CHECK-UP ; RESULT - NORMAL
   c. What treatment was given or recommended? (If none, so state) NONE

(For all "Yes" answers to Questions 3-9, circle items that apply.)

	Yes	No
3. Has Proposed Insured ever had or been treated for:		
a. Disease or disorder of eyes, ears, nose or throat?	☐	☒
b. Dizziness, fainting, convulsions; paralysis or stroke; psychiatric, psychological or emotional disturbance; mental or nervous disease or disorder?	☐	☒
c. Shortness of breath; blood spitting; bronchitis, asthma, emphysema, tuberculosis and other chronic respiratory disease or disorder?	☐	☒
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels?	☐	☒
e. Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gallbladder?	☐	☒
f. Sugar, albumin, blood or pus in urine; stone or other disease or disorder of kidney or bladder?	☐	☒
g. Diabetes; cyst, tumor, or cancer; thyroid or glandular disorder; skin disease or disorder?	☐	☒
h. Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back, or joints?	☐	☒
i. Deformity, lameness or amputation?	☐	☒
j. Allergies; anemia; other blood or lymph disease or disorder?	☐	☒
k. Disorder of prostate, reproductive organs, breasts, menstruation or pregnancy?	☐	☒
4. Is Proposed Insured now under observation or taking treatment?	☐	☒
5. Has Proposed Insured, within the last 10 years, been:		
a. Diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐	☒
b. Treated by a member of the medical profession for AIDS or ARC?	☐	☒
6. Has Proposed Insured, within the last 10 years:		
a. Used, except as legally prescribed by a physician, tranquilizers; barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood-altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances?	☐	☒
b. Received counseling or treatment regarding the use of alcohol or drugs?	☐	☒
7. Has Proposed Insured's weight changed by more than 10 pounds in the last 6 months?	☐	☒

	Yes	No
8. Other than as stated in answers to Questions 2-6, has Proposed Insured, within the last 5 years:		
a. Consulted or been examined or treated by any physician or practitioner?	☐	☒
b. Had any illness, injury, or surgery?	☐	☒
c. Been a patient in or been examined or treated at a hospital, clinic, sanatorium, or other medical facility?	☐	☒
d. Had electrocardiogram, X-ray, other diagnostic test?	☐	☒
e. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?	☐	☒
9. a. Has Proposed Insured, within the last 12 months:		
(i) Smoked Cigarettes?	☐	☒
(ii) Used any other form of tobacco? (Give full details)	☐	☒
b. Has Proposed Insured, within the last 5 years:		
(i) Smoked Cigarettes?	☐	☒
(ii) Used any other form of tobacco? (Give full details)	☐	☒

10. Family History	Age if Living	Cause of Death	Age at Death
Father	75		
Mother	70		
Brothers/Sisters	43+36		

DETAILS FOR "YES" ANSWERS. Include: i. Question Number. ii. Diagnosis and Treatment. iii. Results. iv. Dates and Duration. v. Names and Addresses of all attending physicians and medical facilities. (If additional space is needed, please attach a separate sheet, dated, signed and witnessed as below.)

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance or request for policy change or reinstatement, as the case may be. The Insurer may rely on them in acting on the application or making the policy change or reinstatement.

Dated at NO. BRUNSWICK, NJ (City, State) on 04-04-06 (Mo, Day, Yr.) X _____ Signature of Proposed Insured

Witness (Must be Examiner): _____